INSTRUCTIONS FOR COMPLETION OF THE CDC ADULT HIV/AIDS CASE REPORT
January 2003

The ivory HIV/AIDS case report form replaces all prior HIV and AIDS forms. This form is used to report persons age 13 and over with HIV infection or AIDS (a separate white form is used for reporting HIV or AIDS in children). Instructions for each section of the form are described below. The attached form may be photocopied or more copies of the form may be obtained through your local health department or by contacting one of the numbers listed on the reverse side.

You should report all HIV positive patients with evidence of HIV infection within 7 days of diagnosis, including a physician diagnosis based on history and symptoms. AIDS cases include all patients with any history of HIV infection who also have documented low CD4 levels (defined as under 200 cells/microliter **or** under 14% of total lymphocytes), **or** any of the indicator diseases listed in Section VIII of the form and is to be reported within 24 hours of diagnosis. All required information has been emphasized here in **bold** print.

SIDE 1

SECTION I
Patient Identifiers

For patients with AIDS, enter the patient's full name, current address and phone number. For HIV/not AIDS case reports, the same information is required. However the name field is left BLANK if the patient is tested 1) at a private physician office/HMO and requests anonymity, or 2) at an anonymous counseling and testing site (CTS). **Otherwise, patient name must be entered**. (If you are a state-funded anonymous CTS, please write in the number from the purple CDC-CTS form in place of patient name).

SECTION II

Leave blank all of the grey-shaded areas for "HEALTH DEPARTMENT USE ONLY."

SECTION III
Demographic

Check the appropriate box under Diagnostic Status whether you are reporting "HIV Infection not AIDS" or "AIDS" (the patient meets the 1993 CDC AIDS definition). All information that follows should correspond to the report status specified. "Age at Diagnosis" and "Residence at Diagnosis" fields should reflect when HIV or AIDS was first diagnosed. **Date of birth**, **vital status, ethnicity, race, and sex** should be completed for all anonymous and named reports.

Note: Ethnicity and race are two different variables. The appropriate box must be checked for each variable. If applicable, more than one race may be selected.

SECTION IV

Enter the name and city of the facility/provider where the patient was first diagnosed (as HIV positive or as AIDS, accordingly). Outpatient sites (hospital, ER, CTS, STD clinic, jail, etc.) should be marked as "other" under facility type, and specified in the space provided.

If known, please **indicate if the patient considers him/herself to be Arabic**. (This information is being collected at the request of a community-based organization, which serves the Arabic community.)

SECTION V
Patient History

Check ALL boxes that apply. Write in specific occupation if patient is a healthcare worker.

SECTION VI
Laboratory

Please indicate the first HIV positive result at your facility. Include EIA and Western blot antibody tests, viral loads or other virus detection tests. If laboratory documentation of a positive HIV test is unavailable in the medical record, enter the date of physician diagnosis of HIV infection. A physician diagnosis is made by clinical and/or laboratory evaluation and should be clearly documented (e.g., in progress notes). Prescription of anti-retroviral drugs is sufficient evidence of a physician diagnosis of HIV infection.

Please record the CD4 cell count and percent closest to the current diagnostic status as well as the first CD4 count/percent less than 200/ul or less than 14%. Include date of all tests.

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SECTION VII

List the physician's name and phone number, and the name of the facility submitting the report. **Include the name and phone of the person completing the form**. List the medical record number of the patient if applicable.

SECTION VIII
Clinical

Please indicate whether the clinical record was reviewed. For HIV reports in which the patient was clinically evaluated, enter the date he/she was determined to be symptomatic (with HIV-related conditions) or asymptomatic.

For AIDS reports, check all known indicator diseases and enter dates of diagnosis. Specify whether presumptive or definitive. (Definitive diagnoses are generally based on specific laboratory methods, while presumptive diagnoses are those made by the clinician. A complete description may be found in the MMWR supplement RR-17, Vol. 41, December 18, 1992)

SECTION IX
Treatment/
Referrals

Complete all partner counseling and referral service questions, which include: Has the patient been informed of their HIV infection and who will counsel the patient's partners about their HIV exposure. Under Michigan law, *notifying the known sex or needle-sharing partners of HIV-infected patients is an affirmative duty of the attending physician.* This responsibility may be discharged to local public health by checking the 'Health department' box.

Answer all other treatment questions for which you have information.

For women, list all known obstetrical information as requested. **Please indicate whether the patient is currently pregnant.** Provide birth information in the grey-shaded area, if applicable, for the most recent birth: child's date of birth and address of birth hospital. (Enter "home birth" if born at home). Enter child's name in the comments section at the bottom of the form. Disregard the boxes for Child's soundex and Child's Patient No.

SECTION X
Comments

Please add social security number and any additional laboratory, clinical, or partner counseling and referral service information here.

Completed forms should be mailed to the local health department (LHD) where the patient resides. If this is not possible, mail forms to the LHD where your facility is located, or to HIV/AIDS Surveillance at the Michigan Department of Community Health. When mailing the form, please address the envelope to the AIDS Coordinator or other designated local contact, and mark the envelope "Confidential" or "To Be Opened By Addressee Only."

If you have any questions regarding the use of this form, please contact your local health department, or call HIV/AIDS Surveillance at Michigan Department of Community Health at one of the numbers listed here.

In Southeastern Michigan, contact: 313-876-0353

For all other areas of Michigan, contact: 517-335-8165